RENDERING PROVIDER FORM

Mail to: Department of Mental Health
Chief Information Office Bureau
Systems Access Unit
695 South Vermont Avenue
Los Angeles, CA 90005

Request Type

Submit Date | | | | | | | | New | Update | License Reporting Unit Effective Date | Terminate | Name Change

General Information

Last Name:

First Name:

Middle Initial:

Sex: M F

Ethnicity

DMH/NGA Staff Code

FFS Ind Prov No.

SSN (Last 4 only)

Language Code

Select DMH Classcode:
DMH
Prov name: _____

DHS
Prov name: _____

Non-Governmental Agency (DMH Contracted)
L.E. #: _____
L.E. Name: _____

FFS Individual FFS Group FFS Org

Tax Payer ID (FFS only)

Contact & Assigned Location Information

Contact name: _____ Contact Email: _____

Contact phone no: ( ) _____ Contact Fax No: ( ) _____

Add this rendering provider in the service location indicated below: (please use form MH-228A for additional locations)

Delete this rendering provider in the service location indicated below. Delete this rendering provider in ALL service locations within the legal entity indicated above.

DMH/NGA Prov No./Rept Unit | | | | | | FFS Group/Org Prov No. | | | | | | | | | |
(Please enter the provider no. associated to the above taxpayer ID)

Effective Date | | | | | | Termination Date | | | | | | Locum Tenum | Intern

Name of Organization: _____ Service Area | MHSA

Address: _____ City: _____ Zip: _____

Taxonomy and License Information (Required if request type is NEW)

Description: _____ Taxonomy | | | | | | | | | | |

Professional License # | | | | | | | | | | Effective Date | | | | | | Expiration Date | | | | | |

Description: _____ Taxonomy | | | | | | | | | | |

Professional License # | | | | | | | | | | Effective Date | | | | | | Expiration Date | | | | | |

DEA License # | | | | | | | | | Expiration Date | | | | | |

Medicare Prov No. (DMH directly-operated only) | | | | | | PPIN Medicare No. (DMH directly-operated only) | | | | | | | | Expiration Date | | | | |

NPI | | | | | | | | | | | NPI Effective Date | | | | | |

Authorized Manager/Designee Signature: _____ Print Name: _____ Date: _____

CIOB USE ONLY

Rendering Provider IS No: _____ Ticket # _____

Date Processed | | | | | | Processed by: _____